

FILED JUL 8 1950 STANDARD CERTIFICATE OF DEATH

State File No. **20244**
2794

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. Institution: residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (in this place) 10 yrs		d. STREET ADDRESS (If rural, give location) 2807 Gillham Rd	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2807 Gillham Rd		e. FULL NAME OF HOSPITAL OR INSTITUTION 2807 Gillham Rd	
3. NAME OF DECEASED (Type or Print) a. (First) Hattie b. (Middle) R. c. (Last) Hellberg		4. DATE OF DEATH (Month) (Day) (Year) 6-24-50	
5. SEX Fm	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH June 21, 1896
9. AGE (In years last birthday) 54		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	11. BIRTHPLACE (State or foreign country) N.Y. City N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME Joseph Fischer	
13b. MOTHER'S MAIDEN NAME Maria Holmquist		14. NAME OF HUSBAND OR WIFE James Hellberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT'S SIGNATURE OR NAME Mrs Laura Sumville		ADDRESS 2807 Gillham Rd	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Angina pectoris Myocarditis DUE TO (c) Arteriosclerosis; Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cholecystitis, Cholelithiasis		4201	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **August, 1948**, to **June 4, 1950**, that I last saw the deceased alive on **June 16, 1950**, and that death occurred at **6-23-50 AM.**, from the causes and on the date stated above.

23a. SIGNATURE M. J. Shypper	(Degree or title) M.D.	23b. ADDRESS 1115 Grand, K.C. Mo	23c. DATE SIGNED 6/23/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-25-50	24c. NAME OF CEMETERY OR CREMATORY Oak Grove	24d. LOCATION (City, town, or county) (State) Oak Grove Mo
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DATE REC'D BY LOCAL REG. 6-24-50	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Webb Funeral Home	ADDRESS Oak Grove Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed RB Webb

Signed.....
Student Embalmer

Licensed Embalmer No. 2353

P. O. Address Blue Springs Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.